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Peer Support to Reduce Vicarious Trauma in Mental Health Providers

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Peer Support to Reduce Vicarious Trauma in Mental Health Providers

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Abstract

**Background and Review of Literature:** Mental health providers working with individuals with trauma and stress are at increased risk for vicarious trauma (VT) and compassion fatigue.

**Purpose:** To institute a peer support group for mental health providers with the goal of preventing the negative sequelae associated with vicarious trauma.

**Methods:** A quality improvement project was implemented with six mental health providers engaged in weekly peer support group sessions lead by the DNP student over a six week timeframe. Topics discussed included education on vicarious trauma, client case vignettes, and mindfulness around the treatment of vicarious trauma. Professional quality of life (ProQOL) and secondary traumatic stress (STSS) assessments were completed prior to the start of the peer group and at the completion of the sixth group.

**Results:** Analysis of post group assessment results demonstrated a strong agreement by 67% that peer support is necessary. Additional findings from the peer support groups concluded that connection and the sense of feeling less alone was beneficial, resulting in more clinic camaraderie and individual confidence with patient care. The mental health providers also felt supported by their leadership as a result of their participation.

**Conclusion:** The results of this quality improvement project demonstrate that peer support groups may reduce provider burnout and vicarious trauma and increase compassion satisfaction.

**Keywords:** vicarious traumatization, compassion fatigue, secondary traumatic stress
Introduction

Vicarious traumatization (VT) was first introduced in the early nineties characterized as an individual’s profound negative sequela from working with trauma victims (Culver, McKinney & Paradise, 2011). The repeated exposure to clients’ traumas can cause a negative psychological effect on core aspects of self-identity and perceptions of the world. Mental health professionals in a variety of settings are vicariously traumatized when regularly working with clients who are victims of trauma. The result of this secondary exposure often results in professionals experiencing effects of trauma themselves, effecting patient care and the emotional well-being of the professional.

My voice will go with you. His voice did. What he did not say was that our clients’ voices can also go with us. Their stories become part of us – part of our daily lives and our nightly dreams. Not all stories are negative - indeed, a good many are inspiring. The point is that they change us. (Mahoney, 2003, p. 195).

Background

Everyday behavioral health providers engage in therapeutic encounters that bring them face to face with a myriad of adversities that most will only see through a protected lens. The stress introduced by this line of work is an expected byproduct of the profession. One could argue that it makes intuitive sense that engaging with others in an empathic relationship, characterized by understanding and identifying their emotional experience can similarly impact the experience of the provider. Devilly, Wright and Varker (2009) argue that prolonged occupational exposure with inadequate support to demanding interpersonal situations can lead to psychological strain and moral injury. Vicarious traumatization has been shown to have effects like those suffered by the primary victim. This includes: intrusive images, nightmares, emotional numbing.
disconnection from loved ones and the propensity to abuse alcohol and drugs (Pearlman & Mac Ian, 1995). In the workplace, VT leads to greater physical illness, increased use of sick leave, higher turnover and low morale. Lower productivity leading to patient errors is also found to be greater in those struggling with vicarious trauma. It is estimated that 50% of mental health workers suffer from high or very high levels of trauma from helping others (Conrad & Keller-Geunthar, 2006, p. 1071).

Patient suicide is also a relatively common event: 50–70% of consultant psychiatry providers and 40–50% of psychiatric trainees have experienced at least one patient suicide (Foley & Kelly, 2007, p. 134). Patient suicide, which could also be regarded as an occupational hazard can have significant personal and professional effects on mental health providers, including increased stress, social withdrawal, disruption to relationships, symptoms of post-traumatic stress disorder and consideration of early retirement. Welton and Blackman (2006) opine that one-third of military mental health providers report a sense of responsibility for their patient's death, and more than 20% reported significant emotional or behavioral changes following the death (p. 844). Many providers experienced alterations in their self-esteem and their use of peer consultation following the patient suicide. The current best practices opine that mental health providers derive most support from informal contacts with team members and family and friends versus more formal support structures (Foley & Kelly, 2007).

Core symptoms of VT reported from various mental health professionals describe: anxiety, irritability, cynicism, rage, isolation, phobias, aversions and disillusionment. This all stemming from the endless exposure of stories of violence, cruelty, exploitation and trauma from the darkest places of client’s conditions (Figley, 2002). Sharing these
human experiences can also cause hypervigilance and fear of one’s own safety. Depending on the clinical geographies, at times mental health workers are seeing clients in war zones, amidst prisons and in a variety of different forms of cultural oppression and situational duress.

Pearlman (1995), in a study of 138 Veterans Administration therapists, found that more exposure to combat-related PTSD clients was related to secondary PTSD symptoms in the therapist. Chrestman (1995), in a survey of professional therapists, found that greater exposure to secondary trauma was related to increased levels of intrusion, avoidance, dissociation, and sleep disturbances.

According to Kumar (2016) 80% of physicians suffer from moderate to severe emotional exhaustion (p. 3). This includes feelings of depersonalization, low personal accomplishment and stress. Mental health providers who care for long-term and seriously ill patients are faced with distressing experiences, emotional situations and profound suffering on a daily basis (Lasalvia & Tansella, 2011). Although this is common in clinical practice it can affect the quality of care being given in addition to the provider’s wellbeing. Those working in the mental health field are at even greater risk and have the propensity for adverse patient outcomes (Lasalvia & Tansella, 2011, p. 279). One could argue that empathy is the helper’s greatest asset and also possibly his/her greatest liability.

**Problem Statement**

Mental health providers in a variety of settings are vicariously traumatized from patient suicides and when regularly working with clients who are trauma victims. The product of this secondary exposure often results in professionals experiencing effects of
trauma themselves, effecting patient care and the emotional well-being of the professional. Known evidenced based interventions like peer support, being recommended by this project have shown a reduction in negative psychological symptoms for coping with VT (Myrick & del Vecchio, 2016).

**Review of the Literature**

A comprehensive literature search for vicarious traumatization in mental health providers and treatment was performed using PubMed, Cochrane and the Cumulative Index of Nursing and Allied Health Literature (CINAHL) Plus with Full Text database using the Medical Subject Headings (MeSH) terms ‘mental health providers’ ‘mental health workers’‘vicarious traumatization’ and ‘treatment’. A total of 125 articles were retrieved and reviewed for quality, strength of evidence, applicability and being current using the Johns Hopkins Nursing EBP: Levels of Evidence tool and selected MeSH terms, accessing the Cochrane Database of Systematic Reviews. Cochrane yielded nine results even with the exploded 4 trees, year ranges from 2016 to current, all results were trials. None of the results were for the population of study for purposes of this project: mental health providers/workers. PubMed inclusion criteria included: clinical trials, reviews, full-text, English language and human subjects. Inclusion criteria for CINAHL consisted of full-text, academic articles published in the English language. Excluded from all findings were articles related to compassion fatigue, secondary traumatic stress and vicarious trauma in any other population except mental health providers. This DNP student did an exhaustive literature search and unfortunately, due to the scarcity of scholarly works specific to mental health providers the timeframe for the search was expanded with some applicable articles reviewed dating back to 1984.
Main Findings

Vicarious trauma interventions strive to correct cognitive distortions that arise from trauma experiences and assist professionals to return to a previous level of functioning (Wilson, Friedman, & Lindy, 2001). Craig and Sprang (2010) investigated whether an increased utilization of evidence-based practices, like cognitive behavioral therapy (CBT) would have an impact on VT and compassion satisfaction. The results of this study indicated that evidence-based practices reduce burnout, VT and increase compassion satisfaction. Furthermore, hierarchical regression analyses revealed that having no special trauma training, having an increased caseload of individuals with PTSD and not using evidence-based practices significantly predicted VT. Comparingly, when CBT is utilized with trauma professionals, the interventions focus on how the professional is interpreting their realities which has a direct effect on their coping skills (Inbar & Ganor, 2003). Stress Inoculation Training (SIT) is an example of a cognitive behavioral intervention that has been utilized with individuals and groups to help reduce effects of secondary trauma and increase coping skills while working in stressful or traumatic situations (Inbar & Ganor, 2003). Since publicly funded, community-based behavioral health providers deliver over 70% of psychological care nationwide this group has a great deal to reveal about the factors impacting the manifestation of trauma-induced and work-related problems (Proser & Cox, 2004).

Meichenbaum (2007) describes a multifaceted approach to cope with vicarious traumatization with not only formal, prescriptive therapies as described by Inbar and Ganor (2003) but also whole person approaches as one would approach health care. He posits that on the individual level mental health workers can engage in mindfulness
around symptoms, also known as taking your own “emotional temperature” (p. 14). When symptoms have been recognized one can engage in self-care behaviors to include: relaxation, meditation and massage. Moreover, ensuring physical and emotional well-being for the self. Included in this would be good nutrition, sleep hygiene, regular vacations and exercise. Finally, making conscious effort to stay engaged in activities of renewed meaning of life outside therapy settings. For example, gardening, painting and enjoying nature. Another tool for the management of vicarious trauma involves accessing the cognitive abilities within the mental health worker as a means of recognition that they are not alone in their experience. The results from a randomized control study conducted by Eliacin, Flanagan, Monroe-DeVita, Wasmuth, Salyers and Rollins (2018) implies that work environments where managers support collaboration and social interaction among work teams may reduce burnout. Validating, normalizing and setting realistic expectations about clinical care are also key components of managing VT. Engaging in behavioral activities such as equalized caseloads with victim and non-victim clients and creating a balance in work milieu such as doing more teaching or research are also potential solutions (Meichenbaum, 2007).

Peer and collegial level supports for vicarious trauma include case staffing’s and regular “debriefings” to discuss challenging cases, asking questions like “what do you need right now?” and brainstorming ways the team can support each other. Getting involved in forums or activism around vicarious trauma and attending conferences and furthering education around this phenomenon has also been discussed. Similarly, to the aforementioned researchers, Pearlman and Saakvitne (1995) describe augmenting with Dialectical Behavioral Therapy (DBT) when working with suicidal clients and the use of
short-term group therapy as potential solutions. Peer support, a method of providing for
the well-being of healthcare providers is an emerging second victim treatment modality
that mental health providers deserve the privilege of tapping into as their specialty
provider counterparts have shown positive results with (Vinson & Randel, 2018).

Hodgkinson and Stewart (1998) studied social workers who had counseled
survivors of a train crash and found that sharing their experience with their colleagues
was their main coping strategy. Pearlman and Maclan (1993) found that according to
85% of trauma counselors’ accounts the most common method of dealing with vicarious
trauma was discussion with colleagues (p. 35). Given these points, peer support will
bridge the models of self-help groups and therapy groups focusing on specific problems
or symptoms (VT, Internal Resilience, Normalization). Support groups strengthen “the
central core” of individuals who consider themselves marginal or stigmatized

There are many ways peer support can be offered and available within an
organization. The culture of the organization is a good indicator of whether opportunities
will be provided to deploy group support. Group support can be offered in the forms of
treatment teams, case conferences, group case consultation, or clinical seminars (Bell et
al., 2003). Early, descriptive studies of supportive therapy groups describe outcomes as
expanding social networks, developing caring relationships with group members,
providing advice with problems and improving quality of life (Rosenberg, 1984).

The overarching goal with this quality improvement project is to reduce the
negative psychological symptomatology associated with working with trauma victims.
Experts in second victim trauma, Saakvitne and Pearlman (1996) propose peer support in
addition to requiring organizational involvement in vicarious trauma education and self-care practices to combat those struggling with VT symptoms. This project takes from a multitude of clinical recommendations previously described for mitigating vicarious trauma. The hope is not to eradicate VT but to bring about post-traumatic growth. The physical, psychological, cultural and geographical environment of a mental health provider’s work may predispose him/her to vicarious traumatization. Being personally exposed to oppression, abuse, violence, war and injustice can be a difficult and isolating aspect of the work where many do leave the profession.

The enterprise here should be to treat the most valuable asset to an organization which is the human machine, their staff. We must elicit organizational preventative strategies for VT, deploy peer support services and educate and empower mental health workers to utilize individual components as needed. Neglecting the implications of clinical and organizational correlates to vicarious trauma has led to be costly in terms of staff turnover and low morale. Most importantly, neglect of VT has shown impacts to the quality of patient care and the emotional health of the mental health worker.

To summarize, peer support has proven by overwhelming evidence to incorporate the individual, systemic and organizational level interventions that can facilitate the camaraderie needed to sustain mental health providers in the caring sciences. The literature findings support overall medium to very large positive effects with peer support in the reduction of compassion fatigue, burnout symptoms and an increase in compassion satisfaction.

**Theoretical Framework/ Evidence Based Practice Model**

The theoretical framework selected to guide the healing journey for mental health
providers through vicarious trauma is Dr. Jean Watson’s Theory of Human Caring/Caring Science (see Appendix C for framework). This theory builds on the premise that to enhance professional caring practices in everyday work environments we must create a safe space for self-discovery, validation and professional camaraderie. Core principles include: development of a helping and trusting (human caring) relationship and engaging in an artistry of caring-healing practices. These core principles are in concert with the foundational concepts of treating mental health providers with vicarious trauma using a peer group model. The invitation of storytelling and self-reflection are part of every group guided by Dr. Watson’s theory. Authentic presence is requested from all participants prompted by the peer group leader through the paradigm of one of Dr. Watson’s core principles as a basis for peer interaction in that caring is a global ontology of relation. This helps to not only normalize experiences but also to bring rise to empathy and warmth. Dr. Watson describes this experience as the gateway to successful healing in a helping-trust relationship based on communication. Finally, through the lens of Dr. Watson’s human caring principle the peer support group provides a platform for heart-centered encounters with other persons. When individuals, each with their own phenomenal field/backgrounds come together in a human-to-human transaction that is meaningful, authentic, honoring the person, and sharing human experience, this expands each person’s worldview and spirit, leading to new discovery of self and others and new life possibilities.

**Goals, Objectives and Expected Outcomes**

The goal of implementing peer support was to reduce negative symptoms in mental health professionals associated with vicarious traumatization (VT) and improve job satisfaction. Additionally, we wanted to decrease burnout and secondary traumatic
stress following the completion of the group. The internal goal was to be able to establish organizational resources for professionals to have VT education and evidenced based treatment modalities within one year. Additional ongoing goals will be to increase members’ coping ability in the face of vicarious trauma, provide advice and feedback, share information and build interpersonal skills and camaraderie (Rosenberg, 1984). Participants will be invited to self-disclose, heal each other, and develop a sense of belonging.

Methods

This project introduced a practice intervention executing a quantitative design model, using pre-test/post-test questionnaires. The DNP student also used a repeated-measures analysis (dependent samples t-test) to measure the participants’ vicarious trauma scores from before the peer support was implemented (the pre-test) to after the group was completed (the post-test). One of the main advantages of pre-test/post-test designs is that the associated repeated-measures statistical analyses tend to be more powerful, and thus require considerably smaller sample sizes, than other types of analysis.

Project Site and Population

The site for the Quality Improvement Project was a small private practice in Colorado. The practice was compromised of seven clinicians who serve approximately 18,000 clients per year. The breadth of their services include: integrative mental health, specialized eating disorder treatment, play therapy and transcranial-magnetic-stimulation (TMS) services for children, adolescents and adults. Preference was given to this site because the participants were actively working with trauma clients and had more than
five years of experience. Secondly, given the military influence in the area most of the providers were also working with deployed military personnel and their families. One provider also worked exclusively with sexual assault clients. The conference room was used for the peer groups and had good lighting, privacy, employee amenities like access to food and fluids and easy access of a bathroom. The room dynamics included comfortable chairs arranged in a circle format to encourage discussion and equality.

**Recruitment**

The six direct care mental health providers were recruited via word of mouth by the DNP student directly as there are seven clinicians within the practice. One clinician was excluded from the project due to the inability to attend all the meetings required, so the project was implemented with six providers who signed informed consent (Appendix G). The six participants whom at the time of inquiry were experiencing symptoms of compassion fatigue, secondary traumatic stress and/or vicarious traumatization by self-report. The participant makeup included; a Psychiatric Nurse Practitioner (PMHNP) who was also the owner and site mentor for the project, a Marriage and Family Therapist (MFT), a Licensed Professional Counselor (LPC), a Licensed Vocational Nurse (LVN), a Registered Play Therapist and a Transcranial-Magnetic-Stimulation technician.

**Ethical Considerations/ Protection of Human Subjects**

The DNP student obtained written approval from the project site prior to applying to The University of Massachusetts, Amherst (UMass) Internal Review Board (IRB) (Appendix E). The University of Massachusetts, Amherst (UMass) Internal Review Board (IRB) approval was then obtained prior to initiating the DNP Project (Appendix F). Informed consent using the IRB Generalized Consent form was utilized
for this quality improvement project (Appendix G). The practice intervention project was conducted following the Joint Commissions Standards of Care and the researcher ensured protection of the subjects and project staff. All information collected during the evaluation of this project did not include any potential patient identifiers.

**Description of Peer Support Program**

The peer support program was led by the DNP student under the supervision of a Certified Compassion Fatigue Specialist over a six-week period. The project consisted of six sessions of peer support intervention in a group setting titled: Caring for The Journey - Mending the Mind and The Heart of Healthcare - Sustaining Healthcare's Greatest Assets. Participants took part in one-hour peer support sessions once a week for six weeks. The timeline for the project was November 2019 – March 2020 (Appendix D).

Implementation was over a 6 month period to allow for a phasic execution. Part One was dedicated to recruiting and for the DNP student to design and create the educational modules necessary to execute the project. Copies were procured and resource materials were sourced. Part Two was devoted to executing the actual peer support group with the participants at the site and coordinating appropriate times and dates for the subsequent meetings. Additionally, Part Two also entailed participants completing the pre surveys (ProQOL & STSS) for baseline assessment. Finally, Part Three included data analysis and post surveys.

The DNP student reviewed the following education topics during the six-week series: compassion fatigue, countertransference, posttraumatic stress disorder, secondary traumatic stress, vicarious traumatization and burnout. The peer support sessions consisted of storytelling, case scenarios and didactic exercises about post traumatic
growth and resilience delivered through diverse teaching methods including the use of audio, power point and handouts. The very first meeting of the peer support program included a team building activity to build group cohesiveness and trust. The group participants and DNP student sat in a circle to promote conversation and camaraderie during each session. Prior to the start of each group session, participants were required to review group rules that entail respect and privacy for those participating (see Appendix H for example). The group then commenced with a mindfulness/grounding ritual. Next a round table “check in” would be accomplished to discuss how the week had been and to open the discussion for anyone to bring relevant topics to the conversation. Lastly, the group would move into the education topic of the week and any exercise that was associated with the topic. The final peer support session was built on the psychoeducation learned from previous sessions and then the creation of an authentic, self-care plan and support network (see Appendix J for an example).

**Beginning Sessions.** In weeks 1-2 the main focus was on vicarious trauma psychoeducation and its many synonyms: moral injury, compassion fatigue, countertransference, posttraumatic stress disorder, secondary traumatic stress, vicarious traumatization and burnout. There was also an invitation for those who wished to share to write down and present an impactful patient experience. The DNP student provided clinical vignettes around vicarious trauma and encouraged open group dialogue. Additionally, there was mindfulness training and practice of making occupational awareness a discipline. Questions posed were: What is your opinion of the statement “pain is inevitable, but suffering is optional”? Do you see this as relevant to your experiences of vicarious trauma? If so, how? (Pearlman & McKay, 2008).
**Middle Sessions.** Weeks 3-4 focused on building social supports, resiliency, coping skills, and creating a self-care plan. Discussions were had around health and wellness, including nutrition, exercise, and holistic practices that participants could use. Other topics discussed were balancing caseloads (taking time away from work for rest and relaxation, for friends and family, for spiritual renewal, and for professional development), knowing your limits, mentorship, having difficult conversations and safe places for providers. Example questions posed during the group included: fill in the blanks in this sentence five times, in five different ways: “I sometimes find it difficult to balance ______ with ______” (think about demands, responsibilities, and desires across different people, roles, and situations in your life). What are two issues or themes around which you most frequently feel as if you struggle to find balance?

**Final Groups/ Creation of Self Care Plan.** The final two sessions focused on community and support. Questions posed were: What are two communities that are important to you? How do they “feed you” and help you feel supported and connected? How can you tap into that when you’re feeling empty? During the final session participants were asked to create their own vicarious self-care plan (Appendix J). This worksheet provided by the DNP student includes writing down a buddy system designee, briefing/shift conversation starter, exercise choice, favorite self-talk statement, food/snack plan, meditation, spiritual replenishment and humor.

**Measurement Instruments**

In order to measure the outcomes of this DNP project, two instruments were used prior to the start of the group and after the six sessions were complete: the main measure was the Professional Quality of Life Scale (ProQOL-5), the most commonly used
measure of the negative and positive effects of helping others who experience suffering and trauma (see Appendix A for a copy of the assessment). This quality measure has strong construct validity based on over 200 research reviews (Stamm, 2010). The ProQOL is a 30-item instrument with a 6-point Likert scale (1 = never, 6 = very often) that screens for compassion fatigue, burnout, and compassion satisfaction. Compassion satisfaction is the pleasure gained from having the ability to do the work within one’s profession well (Stamm, 2005). There are three subscales within the ProQOL that are psychometrically unique and cannot be combined with the other scores. The first subscale is compassion satisfaction that has an alpha scale reliability of 0.87. The second, burnout, has an alpha scale reliability of 0.72. Compassion fatigue is the third subscale with an alpha scale reliability of 0.80 (Stamm, 2010).

The second measure: The Secondary Traumatic Stress Scale (STSS) is a 17-item instrument and has a reliability of SD 10; alpha scale reliability 0.81 (see Appendix B for a copy of the assessment). This measure has subscales for intrusion, avoidance and arousal using a Likert scale (1 = never, 5 = very often). The findings from this scale provide the professional with an assessment of the areas of most concern related to the client’s professional work and a starting point for treatment modalities (Stamm, 2010).

On the Professional Quality of Life scale (ProQOL-5) any score above 42 in the compassion satisfaction domain was indicative of a high satisfaction with one’s work. In both the burnout and secondary traumatic stress domains a score of 42 or more was suggestive of vicarious trauma and traumatic stress. The second measure, the Secondary Traumatic Stress Scale (STSS) appraises three domains of traumatic stress specifically associated with secondary exposure to trauma, intrusion, avoidance, and arousal. The
higher the Likert score (5=very often), the higher the self-reported probability of secondary stress associated with that domain.

**Data Collection Procedures**

Pre and post responses of the STSS and ProQOL assessments were collected via paper and pen from the participants directly by the DNP student. The DNP student distributed the assessment measure to each participant individually at the beginning of the first group and at the end of the last group. Responses were anonymous and were compared with pre/post implementation of the peer support program. Comparisons were made by way of random number assignment to maintain confidentiality.

**Data Analysis**

Results from the quality improvement project were used to compare the change in vicarious trauma and secondary traumatic stress within the mental health providers after peer support was instituted. A repeated-measures analysis with the Wilcoxon Signed Rank Test was used to show participants’ vicarious trauma scores improvement from before the peer support was implemented (the pre-test) to after the group was completed (the post-test). This non-parametric test was chosen for the sensitivity to populations that are not normally distributed. Data analysis was also accomplished with basic descriptive statistics (frequencies and means/medians) for the structured-response items. All results were entered and analyzed by the DNP student and data was scored using IBM’s Statistical Package for the Social Sciences (SPSS). The variables of interest were ProQOL and STSS scores both pre and post, self-reported diagnoses and previous/any treatment.
### Results

Six mental health providers participated in the quality improvement project and responded to two assessments measures via a pre/post method: The Secondary Traumatic Stress Scale (STSS) and the Professional Quality of Life Scale (ProQOL).

Table 1

**Professional Quality of Life Scores (ProQOL)**

<table>
<thead>
<tr>
<th>Score</th>
<th>Pre and Post Intervention Mean Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 23, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.</td>
<td>Mean (41) Mean (46)</td>
</tr>
<tr>
<td>If your score is below 23, this probably reflects positive feelings about your ability to be effective in your work. If you score above 41, you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a “bad day” or are in need of some time</td>
<td>Mean (22) Mean (18)</td>
</tr>
</tbody>
</table>
off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

If your score is above 41, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional.

<table>
<thead>
<tr>
<th>Score</th>
<th>Pre-Intervention</th>
<th>Post-Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little or No STS &lt;27</td>
<td>Mean (20)</td>
<td>Mean (19)</td>
</tr>
<tr>
<td>Mild STS 27-34</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate STS 38-43</td>
<td>Mean (33)</td>
<td>Mean (28)</td>
</tr>
<tr>
<td>High STS 44-48</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe STS &gt;48</td>
<td></td>
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</tr>
</tbody>
</table>

Note:
In the preliminary Professional Quality of Life survey, 33% of the participants reported burnout with secondary traumatic stress and 67% reported compassion satisfaction. Additionally, the secondary traumatic stress scale yielded positive responses in 67% of the participants. During dyadic exercises the participants shared that they especially found meaning and appreciation in team building exercises, peer group meals and training days that celebrated taking breaks and self-care.

The post-test statistical outcomes demonstrated a mean compassion satisfaction score of 46, suggestive of a 12% improvement in scores among the participants compared to the pre-test results. Post-test burnout scores reflected a change in mean score by 4 points, an 18% improvement. Finally, the secondary traumatic stress scores showed marked improvement with a reduction in symptoms by 15%.

After investigating the pre and post test results, two major themes evolved from the peer support groups. One being that participants greatly appreciated being less alone in their feelings and wanted to know more about how they could support each other in less formal ways. Secondly, the sharing of how to manage challenging caseloads and overwhelming emotions was invaluable. The data analysis from this project suggests that implementation of peer support for mental health providers should be further investigated to establish creative solutions for integration within organizations. While a peer group was instituted in this case and may work for some, this type of platform is not feasible for everyone. What is certain is that when peer groups feel supported, they perform better, are healthier and have longer careers.
Discussion

The overall project experience was well received by the participants and created a sense of attunement within the team. An unexpected finding, discovered during qualitative questioning and weekly check in was that initially the participants were heavily focused on logistics in patient flow and what they could and could not do to manage their work assignments, thinking the vicarious trauma onus was on them.

Conclusion

The clinical goals for this project were to decrease vicarious trauma, increase compassion satisfaction and create space for post traumatic growth. Working with traumatized patients can alter the world view of mental health providers which can subsequently effect many aspects of their therapeutic efforts. Vicarious traumatization (VT) comes with the territory of working with victimized individuals. Providers struggling with vicarious trauma feel isolated from their peers due to their symptoms (Mahoney, 2003). It has been shown through a research paradigm as well as this quality improvement project, that peer support can be useful in many forms for those struggling with VT symptomatology. Research validates the lasting effects of vicarious trauma on physical, emotional and work place health which warrants the attention of providers and the organizations for which they work. Most mental health providers pride themselves on helping others and no doubt find meaning and purpose in that, however this is only possible when one is healthy, functional and engaged. Best practice for mental health providers working with traumatic material necessitates access to peer support services to mitigate work-related sequelae of VT and ultimately contributes to provider retention through support of professional quality of life.
References


Appendix A

Professional Quality of Life Scale (ProQOL)

_Compassion Satisfaction and Compassion Fatigue_
_(ProQOL) Version 5 (2009)_

When you [help] people you have direct contact with their lives. As you may have found, your compassion for those you [help] can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a [helper]. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the _last 30 days._

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I am happy.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>I am preoccupied with more than one person I [help].</td>
<td></td>
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<tr>
<td>3.</td>
<td>I get satisfaction from being able to [help] people.</td>
<td></td>
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<tr>
<td>4.</td>
<td>I feel connected to others.</td>
<td></td>
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<tr>
<td>5.</td>
<td>I jump or am startled by unexpected sounds.</td>
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<tr>
<td>6.</td>
<td>I feel invigorated after working with those I [help].</td>
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<td>7.</td>
<td>I find it difficult to separate my personal life from my life as a [helper].</td>
<td></td>
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<tr>
<td>8.</td>
<td>I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].</td>
<td></td>
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<tr>
<td>9.</td>
<td>I think that I might have been affected by the traumatic stress of those I [help].</td>
<td></td>
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<tr>
<td>10.</td>
<td>I feel trapped by my job as a [helper].</td>
<td></td>
<td></td>
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<tr>
<td>11.</td>
<td>Because of my [helping], I have felt &quot;on edge&quot; about various things.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>12.</td>
<td>I like my work as a [helper].</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>13.</td>
<td>I feel depressed because of the traumatic experiences of the people I [help].</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>14.</td>
<td>I feel as though I am experiencing the trauma of someone I have [helped].</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>15.</td>
<td>I have beliefs that sustain me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>I am pleased with how I am able to keep up with [helping] techniques and protocols.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>17.</td>
<td>I am the person I always wanted to be.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>18.</td>
<td>My work makes me feel satisfied.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>19.</td>
<td>I feel worn out because of my work as a [helper].</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>20.</td>
<td>I have happy thoughts and feelings about those I [help] and how I could help them.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td>I believe I can make a difference through my work.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td>I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td>I am proud of what I can do to [help].</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>As a result of my [helping], I have intrusive, frightening thoughts.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26.</td>
<td>I feel &quot;bogged down&quot; by the system.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27.</td>
<td>I have thoughts that I am a &quot;success&quot; as a [helper].</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28.</td>
<td>I can't recall important parts of my work with trauma victims.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29.</td>
<td>I am a very caring person.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30.</td>
<td>I am happy that I chose to do this work.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Appendix B

SECONDARY TRAUMATIC STRESS SCALE

The following is a list of statements made by persons who have been impacted by their work with traumatized clients. Read each statement then indicate how frequently the statement was true for you in the past seven (7) days by circling the corresponding number next to the statement.

NOTE: “Client” is used to indicate persons with whom you have been engaged in a helping relationship. You may substitute another noun that better represents your work such as consumer, patient, recipient, etc.

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Often</th>
<th>Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I felt emotionally numb.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. My heart started pounding when I thought about my work with clients.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. It seemed as if I was reliving the trauma(s) experienced by my client(s).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. I had trouble sleeping.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. I felt discouraged about the future.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Reminders of my work with clients upset me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. I had little interest in being around others.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. I felt jumpy.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. I was less active than usual.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. I thought about my work with clients when I didn't intend to.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. I had trouble concentrating.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. I avoided people, places, or things that reminded me of my work with clients.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13. I had disturbing dreams about my work with clients.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14. I wanted to avoid working with some clients.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>15. I was easily annoyed.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>16. I expected something bad to happen.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>17. I noticed gaps in my memory about client sessions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Subscale</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intrusion Subscale (add items 2, 3, 6, 10, 13)</td>
<td>Intrusion Score</td>
</tr>
<tr>
<td>Avoidance Subscale (add items 1, 5, 7, 9, 12, 14, 17)</td>
<td>Avoidance Score</td>
</tr>
<tr>
<td>Arousal Subscale (add items 4, 8, 11, 15, 16)</td>
<td>Arousal Score</td>
</tr>
<tr>
<td>TOTAL (add Intrusion, Arousal, and Avoidance Scores)</td>
<td>Total Score</td>
</tr>
</tbody>
</table>

Appendix C

Dr. Jean Watson’s Human Caring Science Model

1. Sustaining humanistic-altruistic values by practice of loving-kindness, compassion & equanimity with self/other.
2. Being authentically present, enabling faith/hope/belief system; honoring subjective inner, life-world of self/other.
3. Being sensitive to self and others by cultivating own spiritual practices; beyond ego-self to transpersonal presence.
4. Developing and sustaining loving, trusting-caring relationships.
5. Allowing for expression of positive and negative feelings - authentically listening to another person’s story.
6. Creatively problem-solving-‘solution-seeking’ through caring process; full use of self and artistry of caring-healing practices via use of all ways of Knowing/Being/Doing/Becoming.
7. Engaging in transpersonal teaching and learning within context of caring relationship; staying within other’s frame of reference-shift toward coaching model for expanded health/wellness.
8. Creating a healing environment at all levels; subtle environment for energetic authentic caring presence.
9. Reverently assisting with basic needs as sacred acts, touching mind/body/spirit of spirit of other; sustaining human dignity.
10. Opening to spiritual, mystery, unknowns-Allowing for miracles.

WatsonCaringScience.org
Appendix D

Timeline

Table 1

<table>
<thead>
<tr>
<th>Task</th>
<th>October</th>
<th>November</th>
<th>December</th>
<th>January</th>
<th>February</th>
<th>March</th>
<th>April</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruitment of eligible participants/ Pre-Survey’s distributed/ DNP student to acquire all necessary copies and materials for intervention sessions.</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intervention/ midterm evaluation and feedback forum.</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-test and Analysis of outcomes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Results available for stakeholders/ updates to intervention as needed.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
Appendix E

Letter of Support

November 4, 2019

RE: LETTER OF SUPPORT
TO: UMASS IRB

To Whom it May Concern,

Please be advised that the DNP Capstone Project by Alina Kendrick, titled Peer Support to Reduce Vicarious Trauma in Mental Health Providers is a quality improvement project for which the data will be used for the site’s purposes rather than for research.

Sincerely,

[Signature]

Amanda J. Batterbee, PMHNP-BC
President/Owner
North Springs Psychiatry & TMS Center
Appendix F

IRB Determination

UMassAmherst
Human Research Protection Office

Memorandum – Not Human Subjects Research Determination

Date: November 7, 2019

To: Alina Kendrick, Nursing

Project Title: Peer Support to Reduce Vicarious Trauma in Mental Health Providers

IRB Determination Number: 19-194

The Human Research Protection Office (HRPO) has evaluated the above named project and has made the following determination based on the information provided to our office:

† The proposed project does not involve research that obtains information about living individuals [45 CFR 46.102(f)].

† The proposed project does not involve intervention or interaction with individuals OR does not use identifiable private information [45 CFR 46.102(f)(1), (2)].

† The proposed project does not meet the definition of human subject research under federal regulations [45 CFR 46.102(d)].

Submission of an Application to UMass Amherst IRB is not required.

Note: This determination applies only to the activities described in the submission. If there are changes to the activities described in this submission, please submit a new determination form to the HRPO prior to initiating any changes.

A project determined as “Not Human Subjects Research,” must still be conducted in accordance with the ethical principles outlined in the Belmont Report: respect for persons, beneficence, and justice. Researchers must also comply with all applicable federal, state and local regulations as well as UMass Amherst Policies and procedures which may include obtaining approval of your activities from other institutions or entities.

Please do not hesitate to call us at 413-545-3428 or email humansubjects@ora.umass.edu if you have any questions.

Iris L. Jenkins, Assistant Director
Human Research Protection Office
Appendix G
Peer Support Group Consent Form

Consent Form for Participation in a Quality Improvement Project

University of Massachusetts Amherst

Researcher(s): Alina Kendrick
Study Title: Peer Support to Reduce Vicarious Traumatization in Mental Health Providers

1. WHAT IS THIS FORM?
This form is called a Consent Form. It will give you information about the study so you can make an informed decision about participation in this research. We encourage you to take some time to think this over and ask questions now and at any other time. If you decide to participate, you will be asked to sign this form and you will be given a copy for your records.

2. WHAT ARE SOME OF THE IMPORTANT ASPECTS OF THIS RESEARCH STUDY THAT I SHOULD BE AWARE OF?
This project aims to introduce a practice intervention executing a quantitative design model, using a pre-test/post-test strategy. The quality improvement project being proposed will consist of six sessions of peer support intervention in a group setting led by the DNP student titled: Caring for The Journey - Mending the Mind and The Heart of Healthcare - Sustaining Healthcare's Greatest Assets. If you agree to take part in this study, you will be asked to complete a standardized assessment tool (ProQOL and STSS) before and after the evidenced based intervention (peer support) as part of the quality improvement project to assess how much improvement is achieved through the use of peer support. At any time you may skip or choose to forgo questions based on your comfort level.

3. WHY ARE WE DOING THIS RESEARCH STUDY?
The purpose of this research study is to provide education and awareness around vicarious trauma and to reduce the negative psychological symptomatology associated with working with trauma victims through peer support for mental health clinicians.

The long-term goal of implementing peer support is to reduce negative symptoms in mental health professionals associated with vicarious traumatization (VT) and improve job satisfaction.

4. WHO CAN PARTICIPATE IN THIS RESEARCH STUDY?
All behavioral health staff including psychiatrists, psychologists, nurses, social workers and mental health techs from various ethnic backgrounds and include both men and women that range in age from 21 and up. The participant selection will include providers who work directly with clients/patients and are experiencing symptoms of compassion fatigue, secondary traumatic stress and/or vicarious traumatization by self-report. The professional will need to be currently practicing and be working primarily with trauma and/or severe mental health pathology patients. There will be no age requirement. Everyone will be of consenting age and sign informed consent. There will be no geographic or demographic that will be excluded. We would prefer those working directly with trauma clients and with more than five years of experience but will consider those with less and similar clinical experience. We would also prefer those
working with deployed military personnel, victims of human trafficking, and those working with sexual assault/terrorism attacks.

5. WHERE WILL THIS RESEARCH STUDY TAKE PLACE AND HOW MANY PEOPLE WILL PARTICIPATE?
Outpatient integrative mental health clinic in Colorado Springs, CO. There will be at least 6 participants.

6. WHAT WILL I BE ASKED TO DO AND HOW MUCH TIME WILL IT TAKE?
Participation is voluntary while taking part in one-hour peer support sessions once a week for six weeks. The DNP student under the supervision of a Certified Compassion Fatigue Specialist will discuss psychoeducation around theory and research on compassion fatigue, countertransference, posttraumatic stress disorder, secondary traumatic stress, vicarious traumatization and burnout. The group will commence with a mindfulness/grounding ritual with a mantra played from nurse theorist Dr. Watson’s soundtrack and a round table “check in” about how the week has been and if any member has something to bring to the group or something that has come up for them that they wish to share. The following peer sessions will consist of storytelling, case scenarios and dyadic exercises about post traumatic growth and resilience. The final peer support sessions will build on the psychoeducation learned from previous sessions and the creation of an authentic, sustainable, self-care plan and support network. The aforementioned will be delivered via audio, power point and handouts with clinical vignettes for the discussion exercises.

7. WILL BEING IN THIS RESEARCH STUDY HELP ME IN ANY WAY?
You may not directly benefit from this research; however, we hope that your participation in the study may foster post traumatic growth, compassion satisfaction and a sense of community with your peers. Finally, we hope that this group builds on internal resiliency with the idea of being less alone in your occupational journey.

8. WHAT ARE MY RISKS OF BEING IN THIS RESEARCH STUDY?
We believe there are minimal risks associated with this research study; however, a risk of breach of confidentiality always exists and we have taken the steps to minimize this risk as outlined in section 9 below and in the group rules reviewed prior to each group session.

9. HOW WILL MY PERSONAL INFORMATION BE PROTECTED?
Your privacy and confidentiality is important to us. The following procedures will be used to protect the confidentiality of your study records. The researchers will keep all study records, including any codes to your data, in a secure location. Subjects identified to take part in the project will be protected by the Health Insurance Portability and Accountability Act (HIPAA). The subjects will have Personally Identified Information (PII) protected. All data will be password protected and hard copies will be kept behind locked doors.

Your name or information will not be revealed in any documents related to this project implementation. At the conclusion of this project, the project coordinator may publish their findings. Information will be presented in summary format and you will not be identified in any publications or presentations.
10. WILL MY INFORMATION (BIOSPECIMENS OR PRIVATE INFORMATION) BE USED FOR RESEARCH IN THE FUTURE?
Identifiers might be **removed** and the de-identified information may be used for future research without additional informed consent from you.

11. WILL I BE GIVEN ANY MONEY OR OTHER COMPENSATION FOR BEING IN THIS RESEARCH STUDY?
Participants that complete the study are given a $25 Amazon gift card and will also be provided refreshments at every group meeting.

12. WHO CAN I TALK TO IF I HAVE QUESTIONS?
Take as long as you like before you make a decision. We will be happy to answer any question you have about this study. If you have further questions about this project or if you have a research-related problem, you may contact the researcher(s) Alina Kendrick (678)982-2994.

If you have any questions concerning your rights as a research subject, you may contact the University of Massachusetts Amherst Human Research Protection Office (HRPO) at (413) 545-3428 or humansubjects@ora.umass.edu.

13. WHAT HAPPENS IF I SAY YES, BUT I CHANGE MY MIND LATER?
You do not have to be in this study if you do not want to. If you agree to be in the study, but later change your mind, you may drop out at any time. There are no penalties or consequences of any kind if you decide that you do not want to participate.

14. WHAT IF I AM INJURED?
The University of Massachusetts does not have a program for compensating subjects for injury or complications related to human **subjects** research, but the study personnel will assist you in getting treatment.

15. SUBJECT STATEMENT OF VOLUNTARY CONSENT
When signing this **form** I am agreeing to voluntarily enter this study. I have had a chance to read this consent form, and it was explained to me in a language which I use. I have had the opportunity to ask questions and have received satisfactory answers. I have been informed that I can withdraw at any time. A copy of this signed Informed Consent Form has been given to me.

Participant Signature: ___________________________ Print Name: ___________________________ Date: ___________________________

By signing **below** I indicate that the participant has read and, to the best of my knowledge, understands the details contained in this document and has been given a copy.

Signature of Person Obtaining Consent: ___________________________ Print Name: ___________________________ Date: ___________________________
Appendix H

Peer Support Group Rules

1. What is said here stays here. Don’t break group member confidentiality and/or those we serve (no identities revealed— use as little identifying information as possible while talking).
3. Be open to feedback.
4. NO ONE has to participate or take part if uncomfortable.
5. The opinions, comments and questions of others are welcomed and respected.
6. Avoid giving advice and “fix-it mode”.
7. Speak “I” language (speak for yourself).
8. Respect the talker—no cross talk.
9. Be Mindful of your Body Language (sighing, rolling eyes, facial gestures, arms crossed, etc.). Be “open”, not “closed”.
10. Remember, it’s okay to compromise. It’s okay to agree to disagree.
11. Avoid mind reading. When in doubt, check it out.
12. Only talk about group members that are present (nothing about ya withoutcha).
13. While there is an agenda we can veer off topic if it’s productive.
14. We respect breaks as needed and encourage you to take them to take care of yourself if/ when needed.
15. Respect the group by showing up, regularly and on time.
### Appendix I

**Cost Analysis**

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paper Copies w/ plastic covers</td>
<td>$50</td>
</tr>
<tr>
<td>Transportation</td>
<td>$600</td>
</tr>
<tr>
<td>STSS/ ProQOL-5</td>
<td>$0</td>
</tr>
<tr>
<td>Peer Group Binder</td>
<td>$10</td>
</tr>
<tr>
<td>Dr. Jean Watson’s Human Caring Theory: Ten Caritas Processes Cards (20)</td>
<td>$30</td>
</tr>
<tr>
<td>DNP student time for creating PPT, organizing videos, creating a binder with module based programming and development of vignettes</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$690</strong></td>
</tr>
</tbody>
</table>
Appendix J

**Wellness Recovery Action Plan / Self Care Plan**

“What doesn’t move through us, defines us”
Let us fearlessly examine and re-examine our helping and caregiving motives.
“Nous allons en arriere, ameliorer le saut”
“we go backwards to better to jump”

What I am like when I am feeling well:

**Battle Buddy/ Mentor:**

What specifically do you need from this person/ task?

**Briefing/ shift conversation starter:**

**Exercise choice:**
Favorite self-talk statement:

**Food/snack plan:**
Notebook to jot things down (memory is impaired when stressed):
Meditation/ relaxation:

**Spiritual Replenishment:**

**Humor:**

I value my health and my service to the community so much that I do not want to compromise my wholeness and potentially, hurt myself or others. I take my social and emotional health very seriously and commit to making occupational awareness a priority:

____________________________________________

Signature